Testimony before the Human Services Committee

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Good morning, Senator Slossberg, Representative Abercrombie and distinguished members of the Human Services Committee. My name is Roderick Bremby and I am the Commissioner of the Department of Social Services. I am pleased to appear before you today to testify on several bills that were raised on behalf of the department. In addition, I offer testimony on several other bills that impact the department. I would like to thank the Committee for raising the bills on our behalf and urge your support. I will begin my comments with the department's bills.

BILLS SUBMITTED BY THE DEPARTMENT

H.B. No. 6368 (RAISED) AN ACT CONCERNING THE CHOICES HEALTH INSURANCE ASSISTANCE PROGRAM.

This proposal seeks to revise CGS§17b-427 to reflect updated terminology as well as eliminate duplicative program requirements that are currently provided by the federal government. At the time this statute was created, federal resources regarding healthcare options for the elderly were scarce. The intent was to ensure that the elderly had access to the necessary information in order to make informed healthcare decisions. Today, the Centers for Medicare and Medicaid Services (CMS) has dramatically improved the information available to their beneficiaries, including the use of electronic media to ensure greater consumer access. Therefore, certain requirements of this statute are duplicating efforts that are already being done elsewhere.

Upon review of the proposal, we note that provisions were added to the language submitted by the department to the committee. These appear to be technical in nature and we are not opposed however, we offer the following recommended changes. In section 2 the reference to the "Select Committee on Aging" should be replaced with "joint standing committee of the General Assembly having cognizance of matters relating to aging" and "Commissioner of Social Services" should be replaced with the "Commissioner on Aging."

H.B. No. 6369 (RAISED) AN ACT CONCERNING CHILD SUPPORT AND ENFORCEMENT.

FIRST, this bill would standardize the percentage used by the courts to determine reasonable cost for a parent to obtain health insurance for his or her child. Such standard is used in determining the appropriateness of various health care coverage orders. Currently reasonable cost is computed using two different percentage rates. When a noncustodial parent is deemed to be a low income obligor pursuant to the child support guidelines, reasonable cost is five percent of net income. In all other cases, reasonable cost is seven and one half percent of net income. This bill would set a single percentage used to determine reasonable cost for health insurance to five percent of gross income. The use of a single percentage based on gross income will be easier for employers to implement when required to determine if available coverage is within the percentage set by the court. Because of the variations in allowable employer deductions and the additional deductions that are authorized in the child support guidelines, net income calculations for the purpose of health care coverage can be difficult to understand. Gross income is easy to understand for both parents and employers.

Also the current 2-tier system provides orders that are based on the income level of the obligor at the time the order is entered by the court. Should the obligor's income change after the fact, the order may no longer be fair. A single percentage would eliminate this possibility, as well as avoid the necessity for a modification thus saving the court, judicial staff and the parties both time and money.

When it comes to providing medical insurance, differentiating between "low-income" and not "low-income" income ranges is irrelevant in practice. In practical terms, if a parent is "low-income" based on the Child Support and Arrearage Guidelines, the likelihood of employer based health coverage being available at less than 5% of an employee's gross income is extremely low. For a parent working 40 hours at the state minimum wage of $8.25/hour, gross weekly earnings are $330. At 5% of gross, the reasonable cost benchmark is $16.50. At 3.5% of gross it is $11.55. Research by the Agency for Healthcare Research and Policy indicate the average employee contribution for an employee plus one health insurance plan in Connecticut in 2011 was $2,759/year or $53/week.

Second, this bill would permit judicial marshals to execute capias mittimus orders using a copy of the original document. This is currently the protocol for state marshals and special police officers. Providing the judicial marshals a capias mittimus order in a timely manner at a courthouse where criminal and motor vehicle matters are being heard will increase the likelihood of effectuating the arrest. Also with an increase in arrests, there would be a corresponding increase in the collection of child support arrearages owed to both the custodial parent as well as the State of Connecticut.

Finally, this bill would grant the Department of Social Services Special Police Officers access to the Connecticut On-Line Law Enforcement Communications Teleprocessing system (COLLECT). COLLECT provides national criminal information from the National Crime Information Center (NCIC) and the International Justice and Public Safety Information Sharing Network. The Department of Social Services currently employs four special police officers as authorized in CGS §29-1g to act as Child Support Capias Officers within the Bureau of Child Support Enforcement. Currently these officers have been denied access to the COLLECT system, as a capias mittimus is considered a civil warrant as opposed to criminal warrant, despite the provision of CGS §29-1g, which states that child support special policeman "shall have all the powers conferred on state policemen."

The primary function of these officers is to execute capias mittimus orders, which are civil arrest warrants ordered by family support magistrates in Title IV-D cases. Many obligors are found to have extensive criminal records, including violent offenses. The COLLECT system gives the arresting officer vital information as to the criminal history as well as other pertinent information including outstanding criminal warrants. With access to the COLLECT system, DSS Capias Officers will be able to determine the level of threat associated with each execution of a capias mittimus and afford them the greatest measure of safety. In addition, Capias Officers are mandated, by virtue of their certification as police officers, to respond in support of state and local police officers and assist those officers should an occasion arise during the course of their daily activities.

The Department of Social Services currently has access to COLLECT within the Family Services Daycare Unit. This access is used to investigate those individuals who are making application to become licensed daycare workers. As a result, should the department's Special Policemen be granted access to COLLECT, it could be done so without any additional expense to the department.

S.B. No. 852 (RAISED) AN ACT CONCERNING NURSING HOME OVERSIGHT AND COMMUNITY-BASED PLACEMENTS.

Over the last few years, the department has seen a rise in the number of nursing facilities filing for bankruptcy, falling under court-ordered receivership and/or seeking to close. These situations can cause great disruption in the lives of the residents and workers in these facilities. In most cases, once a facility has reached this point, the fate of the facility is sealed. The department believes that with greater ability to access and analyze financial data of certain facilities failing to meet a basic census threshold, we can identify those facilities that may be in danger of bankruptcy, receivership and/or closure and assist them with an appropriate plan that meets the needs of residents, workers and management.

In addition, this proposal seeks to allow the department's Money Follows the Person (MFP) program to offer their community placement services earlier. The proposal requires any nursing

facility filing a Letter of Intent (LOI) with the department to give the Long Term Care Ombudsman and the department written notice of the facility's intent, 30 days prior to filing the LOI. In addition, this section requires such facilities to allow the department to evaluate residents at the facility to determine those who may be eligible to transition to a community-based setting under the Money Follows the Person program.

When a nursing facility applies to the department for a Certificate of Need to close, it is in the state's and residents' interests to offer the option of transitioning to the community to all residents for whom that option is appropriate. However, in many cases, by the time the department's Money Follows the Person program staff are able to enter a facility and begin to assess residents, it is often after many residents have already moved to other facilities. This is because, in closure situations, the department is often not given prior notice of the facility's intent to close until a Letter of Intent is filed. This proposal will allow the MFP program to intervene at an earlier point, providing more meaningful choices to residents.

S.B. No. 854 (RAISED) AN ACT CONCERNING SOCIAL INNOVATION INVESTMENT.

This proposal provides necessary statutory authority for the state to pursue a new type of funding mechanism for social programs where government, private investors, and nonprofit service providers partner to fund and deliver preventive social programs. In these times of limited government funding, we must begin to think of innovative ways to fund our critical social programs.

Social innovation investment enterprises are public/private partnerships governed by performance-based contracts. These partnerships can take various forms, but simply stated, government entities contract with private non-profits to provide program services and establish a vehicle for up-front, private investment. Investors receive a return on their investment when contractually defined performance targets are achieved.

Social Innovation investment is a structure that is quickly gaining wide-spread support and there are a few models being implemented in other states, most notably, in Massachusetts and New York.

S.B. No. 855 (RAISED) AN ACT REVISING CERTAIN SOCIAL SERVICES STATUTES.

This proposal seeks to accomplish a number of goals. First, it proposes to eliminate two statutory reporting requirements. In addition the proposal changes the date by which the department must submit the annual LIHEAP allocation plan from August 1 to October 1 in order to coincide more closely with the release of federal fund estimates. Second, the bill proposes to amend CGS§ 17b-8 so that the department is not required to appear before the committees of cognizance on a

waiver provision that has been legislated. Lastly, this bill amends the statute pertaining to disability determinations to reflect our regulations, the Uniform Policy Manual and current practice.

Sections 1 and 3 propose to eliminate reporting requirements related to three of our block grant programs, LIHEAP, SSBG and CSBG. The department is required to appear before the committees of cognizance every fall to present our annual block grant allocation plans which the committees vote to approve, reject or modify. The committees have thirty days from the date the plan is presented to them to make a decision, giving the committees ample time to review program statistics from the previous year. The additional reporting requirements are due in the midst of the program cycle when our focus should be on providing the services funded under these block grants in accordance with the plans as submitted to and approved by federal agencies.

Section 2 proposes to create an additional exception to the hearing requirement for Medicaid waivers when such waiver has been legislated. The submission of a waiver application to the Centers for Medicare and Medicaid Services is time consuming and complex. Typically when a Medicaid waiver is legislated, it is associated with budgetary savings that must be achieved within particular timeframes. It is only in those instances where there is clear legislative intent that we seek an abbreviated submission process in order to comply with the legislative mandate and achieve budgetary savings.

Lastly, section 4 merely amends the statute to conform with practice and regulation that were implemented in 1990. Since 1990, the department's Uniform Policy Manual reflects a standard of promptness of ninety days for applications where a disability determination is needed (UPM 1505.35(C)(c)). The statute was never amended to reflect this regulation.

OTHER BILLS AFFECTING THE DEPARTMENT

S.B. No. 27 (COMM) AN ACT PROMOTING THE PURSUIT OF EDUCATION BY RECIPIENTS OF ASSISTANCE.

The bill appears to benefit recipients of the Temporary Family Assistance (TFA) program who are required to participate in the Jobs First Employment Services (JFES) program. The purpose of the bill is to allow and to encourage certain educational pursuits such as the attainment of a high school diploma or equivalent or the attainment of a two-year or four-year college degree while also participating in other mandatory work activities as prescribed by the JFES program as established by PRWORA.

JFES currently allows and encourages teen parents (under age 19) to focus on completing a high school degree or the equivalent. Currently, section 17b-688i requires the Department of Labor

(DOL) to include access to basic education as appropriate. In addition, section 17b-689c requires DOL to perform initial assessments in education and to determine basic educational needs as a part of the Employability Plan for JFES participants. Also, JFES participants are permitted to participate in two and/or four year degree programs when the state unemployment rate is eight percent or greater for the preceding three months as described in section 17b-112j. Participants rely on their own source of funding such as Pell grants and other scholarship programs. However, other supports such as transportation and childcare are available for eligible participants.

The bill does not include any additional appropriations for the JFES program, and funding college degree programs is cost prohibitive. Furthermore, as it stands, this bill would expose the state to penalties for not meeting the federally mandated work participation rate. Therefore, we cannot support this bill.

S.B. No. 93 (COMM) AN ACT CONCERNING THE COMMUNITY SPOUSE OF AN INSTITUTIONALIZED PERSON & S.B. No. 851 (RAISED) AN ACT PROTECTING THE ASSETS OF THE SPOUSE OF AN INSTITUTIONALIZED MEDICAID RECIPIENT.

These bills propose to allow the spouse of an institutionalized person who is applying for Medicaid (referred to hereafter as the "community spouse") to retain marital assets up to the maximum allowed under federal law. Effective January 1st, 2013, this amount is $115,920. Under current statute, community spouses of long-term care Medicaid recipients are allowed to keep one-half of the couple's liquid assets up to the federal maximum. If the total of the assets are under the minimum allowed by federal law ($23,184), the community spouse may keep all of the assets. The couple's home and one car are excluded from the assessment of spousal assets.

Allowing community spouses to keep up to the maximum allowed would have a significant, negative fiscal impact. In 2010, the legislature passed Public Act 10-73, which did exactly what this bill proposes, to allow the community spouse to retain up to the federal maximum. It was reversed in the 2011 legislative session due to the projected additional costs of over $31 million to the 2012-2013 state budget.

To demonstrate the potential fiscal impact of this change, we offer the following two examples.

1. Mr. S entered a nursing home on January 1, 2013. The spousal assets as of that date were $80,000. They applied for Medicaid on January 1, 2013.

Under the current rules, Mrs. S is allowed to keep one-half of the spousal assets ($40,000), plus the home and one car. The couple reduces their assets of $80,000 to $40,000 for Mrs. S and $1,600 (the Medicaid asset limit) for Mr. S in February 2013 and DSS grants Medicaid eligibility for Mr. S. They spend $11,000 of their money on Mr. S's nursing home care – approximately one month's worth of care. The rest of the money is spent on funeral contracts and home repairs.

Under the proposed legislation, Mrs. S would automatically be allowed to retain assets up to $115,920 – the maximum amount allowed under federal law. Since their assets were below this amount when Mr. S was admitted to the nursing facility, Mr. S would have been immediately eligible for Medicaid, shifting cost of nursing home care for one month to the state's Medicaid program.

2. Mr. H entered a nursing home on January 1, 2013. The spousal assets as of that date were $150,000. They applied for Medicaid on January 7, 2013.

Under the current rules, Mrs. H is allowed to keep one-half of the spousal assets ($75,000) plus the home and one car. The couple reduces their assets of $150,000 to $75,000 for Mrs. H and $1,600 (the Medicaid asset limit) for Mr. H by May 2013 and DSS grants Medicaid eligibility for Mr. H. They spend $35,000 on home repairs for Mrs. H and $40,000 on Mr. H's nursing home care – approximately 3½ months of care.

Under the proposed legislation, Mrs. H would automatically be allowed to retain assets up to $115,920 – the maximum protection amount allowed under federal law. They would only need to spend $32,480 to be eligible ($150,000 - $115,920 for Mrs. H - $1,600 for Mr. H), which they can accomplish through the home repairs. They would not need to spend any money on Mr. H's care and would therefore shift the cost of care for 3 ½ months of care to the state's Medicaid program.

The focus of Senate Bill 93 is on the length of time that the Community Spouse Protected Amount (CSPA) would be allowed, namely "a period of five years after the institutionalized spouse becomes eligible for Medicaid". This concept has no meaning or consequence, as once the CSPA is established and attained through appropriate measures, no further asset review is required. Community spouses are allowed until the first redetermination of the Medicaid case to transfer the pertinent assets out of the applicant's name and satisfy the terms of the spousal assessment. Subsequent to this, no further asset review is conducted for the community spouse.

The Department continues to maintain that the current policy, which has been in place since 1989 (with the exception of FY 2011), is fair and reasonable and supports the original intent of the 1988 Medicare Catastrophic Coverage Act, which seeks to prevent the impoverishment of spouses of those applying for Medicaid coverage for long-term care. Our current policy is also in line with most other states – there are only 13 states that allow the community spouse to retain assets up to the maximum allowed. We do not support this bill as it would require additional funding of over $31 million in the Medicaid account.

H.B. No. 6370 (RAISED) AN ACT EXPANDING ELIGIBILITY FOR SUBSIDIZED ASSISTED LIVING.

The Assisted Living demonstration project administered jointly by the Department of Social Services and CHFA includes four subsidized assisted living communities in Hartford, Glastonbury, Seymour and Middletown. CHFA administers the program and provides rental

subsidies (appropriated to DECD and transferred to CHFA). The assisted living services are provided through DSS' CT Home Care Program for the Elderly.

Currently, in order to be eligible to reside in one of the subsidized assisting living units, an applicant must be eligible for the CT Home Care Program. This proposal would allow DMHAS Mental Health Waiver recipients 65 and older to also be eligible to participate. This proposal does not seek to add any new slots or appropriate new money. It merely allows those participating on the DMHAS Medicaid waiver to also apply for the program.

This proposal was brought to the Interagency Workgroup for the demonstration project, which includes representatives from OPM, CHFA, DSS, DPH, and DECD, and is supported by all parties.